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Stuck in the middle? A perspective on ongoing pro-competitive reforms in Dutch mental health care☆

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ABSTRACT

Pro-competitive reforms have been implemented in many Western healthcare systems, of which the Netherlands is a prominent example. While the pro-competitive reforms in the Dutch specialized care sector have drawn considerable academic attention, mental health care is often excluded. However, in line with other segments of specialized care, pro-competitive legislation has formed the core of mental health care reforms, albeit with several notable differences. Ever since mental health services were included in the Health Insurance Act in 2008, the Dutch mental healthcare sector has been in an ongoing state of reform. Numerous major and minor adaptations have continuously altered the services covered by the basic insurance package, the actors responsible for providing and contracting care, and definitions and measurements of quality. Most notably, insurers and municipalities, which are responsible for selectively contracting those providers that offer high value-for-money, seem insensitive to quality aspects. The question whether the Dutch mental health sector has inherited the best or the worst of a competitive and non-competitive system lingers and international policy makers contemplating reforming their mental health sector should take note.

1. The purpose of pro-competitive reforms

Reforms introducing managed competition in healthcare markets have gained a prominent role on policymakers' agendas over the past decades [1,2]. Albeit in different forms, pro-competitive legislation has been introduced in several countries, of which the United States and the Netherlands are prominent examples [3,4]. The essential assumption underlying these reforms is that introducing (managed) competition in healthcare markets will lead to maximum value for money for consumers [4]. However, the specific nature of demand, supply conditions, uncertainties, and pricing strategies in health care [5] make the link between introducing competition and the envisaged benefits difficult to predict. While the ultimate goal of the reforms is to enable the system to deliver good–or even better–care, at lower costs, outcomes of pro-competitive healthcare reforms are far from straightforward. In fact, a wide and rich scholarly debate has addressed the implications of competition in healthcare [6,7]. Yet, a *meso* perspective that focuses on the strategic

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behavior – and reaction – of organizations is lacking. Moreover, when it comes to competition in healthcare, several studies have considered the Netherlands but few have focused on the mental health sector. This paper discusses the ongoing pro-competitive reforms in Dutch curative mental health care. It considers the perspective of purchasers (i.e. insurers and municipalities) and mental healthcare providers in the sector.

2. Reforming mental health: an ongoing process

The introduction of the Health Insurance Act (HIA) in 2006 is generally considered synonymous to pro-competitive reforms in Dutch healthcare [3]. However, pro-competitive reforms have been implemented as a bundle of subsequent incremental measures rather than with a 'big bang' approach [8]. Hence, the introduction of the HIA in 2006 marks the beginning of an era in which Dutch policy makers have attempted to build competitive elements into their healthcare system. The mandatory basic insurance package, introduced by the HIA [3], initially did not include coverage for mental health services. In 2008, two years after the introduction of the HIA, all curative mental health services, focused on curing patients within one year, were shifted from the Exceptional Medical Expenses Act (EMEA) to the HIA [9]. Long-term mental health services (i.e. requiring treatment longer than 1 year) and forensic mental health services remained covered by the EMEA [10]. As a result, insurance companies became responsible for contracting curative mental health services. Primary care providers (e.g. psychologists) were contracted on a per-consultation basis, for which price was freely negotiable. Contracting of secondary providers (e.g. mental health hospitals) revolved around newly introduced DRG-like products called Diagnosis Treatment Combinations (DTCs). Contrary to DTCs in other segments of specialized care, the national health authority set maximum prices for all DTCs in mental health care [9], although providers and insurers were free to negotiate for a price below the maximum amount [11].

Since 2008, Dutch curative mental health has been in a near-ongoing state of reform. Coverage for a number of services was removed from the basic insurance package in 2010, 2012, and 2013. Co-payments were introduced in 2012 and (partially) removed in 2013 and 2014. National budget reductions were enacted in 2010 and 2015, reducing the maximum budget available for mental health care. The DTC structure for inpatient services was revised in 2012. The mandatory deductible ('eigen risico'), which requires patients to pay a specific amount of treatment costs out-of-pocket, was increased annually. Budgeting of secondary mental healthcare providers was discontinued in 2014, requiring them to adopt the DTC structure, and several quality enhancing initiatives were undertaken by stakeholders.

In 2014, mental health was divided into two segments in order to create a more effective and efficient sector capable of delivering services close to the patients' home, without co-payments, [11,12]. Patients with mild mental health problems were to be treated by primary care providers (i.e. GPs, assisted by mental health physician assistants). Consequently, the number of consultations conducted by these physician assistants more than doubled in 2014 [13]. Patients with moderate mental health conditions are referred to the 'generalist basic mental health' segment by their primary care provider, while patients with severe mental health conditions are referred to 'specialized mental health' [11,12]. The maximum treatment price in both of these segments is defined by the health authority.

In 2015, curative mental health was redefined to include treatment of patients up to three years, shifting coverage of all treatments lasting between one and three years from the EMEA to the HIA. At the same time child and youth mental health services, with the exception of pharmaceuticals and services offered by primary care providers, were shifted from the HIA to the Youth Act (YA). Consequently, municipalities were responsible for both social care and (purchasing of) mental health care for children under the age of 18, which constitutes almost a quarter of the patient population in Dutch mental health [14,15]. See Table 1 for an overview of the reforms in Dutch mental health care since 2008.

3. Battling for bargaining power

In 2013 approximately 1.3 million people received mental health care services which were covered by the basic insurance package. The 4.3 billion Euro spent on those services constitute 10% of the total spending in the basic package [14,16]. Secondary (i.e. specialized) mental health services account for roughly 92% of the spending [17], even though less than 10% of the patients are admitted to a secondary mental health provider for at least 1 night [15,18]. In 2012, an estimated 6000 primary mental health providers (e.g. psychologists), 265 secondary mental healthcare organizations, and 3000 independent secondary practitioners offered mental health services [11]. However, 37 providers are responsible for more than half of the (curative and long-term) mental health expenditures in the Netherlands [11]. The prices of these providers have increased between 2008 and 2011 [11], leading some researchers to conclude that providers are able to exercise bargaining power [19].

Between 2008 and 2014, nine insurance companies contracted providers for curative mental health services. Four insurers decided to jointly contract mental health providers, through a collective agreement [20]. Of the remaining five insurers, the four largest possess a combined 89% market share [21]. Between 2008 and 2012 the Herfindahl-Hirschman Index (HHI), a measure which indicates the degree of competition in a market (i.e. a value above 2.5 is typically seen as an indicator of a highly concentrated market [6].), of the health insurer market has consistently exceeded 2.1 at national level and exceeded 3.0 in eight of the country's twelve provinces in 2012 [22]. Until 2014 it was furthermore possible for one insurance company (i.e. the largest in a specific region) to negotiate on behalf of all other insurance companies [11]. The fact that prices of independent secondary providers have decreased between 2008 and 2011 leads other researchers to conclude that insurance companies are able to exercise bargaining power [11].

Table 1
Reforms in Dutch mental health care between 2008 and 2015. Based on [9–11,20,21,25,29–31].

	2008	2009	2010	2011	2012	2013	2014	2015
Sector	Financing of curative mental health services shifted from Exceptional Medical Expenses Act (EMEA) to Health Insurance Act (HIA)	Governmental approval for construction activities no longer required					Restructuring of primary and secondary curative mental health into 'General basic mental health' and 'Specialized mental health'	Financing of mental health for children below the age of 18, ambulatory coaching, day care, and protected living shifted from HIA to Youth Act and Social Support Act Financing of mental health services lasting between 1 and 3 years shifted from EMEA to HIA
Purchasing	Introduction of Diagnosis Treatment Combinations (DTCs) in curative secondary mental health		Budget reduction of € 119 million imposed	Advanced payments for non-budgeted providers introduced	New product structure for inpatient mental health services Maximum price of some DTCs reduced and no-show no longer billable Providers and insurers allowed to introduce new services in primary mental health	Introduction of macro level cost containment tool Budgeting removed (i.e. all financing per DTC)	Prices in mental health re-evaluated by healthcare authority. Maximum prices for inpatient care increased by 10%. Representation purchasing removed	DTC structure for mental health for children no longer obliged but upheld by most municipalities Municipalities are required to reduce budget of mental health services for children under the age of 18 but are free to allocate resources themselves
Coverage			'Psychoanalysis' removed from the basic package		'Adjustment disorder' removed from basic package Number of consultations in primary mental health covered by the basic package reduced	'Other conditions which are a reason for concern' removed from the basic package		
Co-Payments					Co-payments in primary mental health increased Co-payments for inpatient mental health introduced	Co-payments in secondary mental health removed	All co-payments in mental health removed	
Deductible	Mandatory voluntary deductible introduced	Mandatory deductible increased	Mandatory deductible increased	Mandatory deductible increased	Mandatory deductible increased	Mandatory deductible increased	Mandatory deductible increased	Mandatory deductible increased
Quality of care	'Knowledge Center Health' created by health insurers	Project ROM started by 'Mental Health Netherlands'	CQ-index outpatient mental health services obligatory Providers expected to report ROM measures for 20% of all DTC	Number of performance indicators reduced.	Privacy regulation for DTC billing process introduced Performance indicators redefined and ROM indicators obliged method to measure treatment effectiveness		Providers expected to submit ROM-measurements for 50% of all DTCS	Additional professions are considered appropriate to be 'in the lead' of a treatment

As of 2015, child and youth mental health services are purchased by the 393 Dutch municipalities [23], presenting providers with more potential purchasers of their services. However, municipalities lack experience in purchasing (mental) health services, which is likely to increase transaction costs, in terms of longer and more difficult negotiations due to information asymmetries. Furthermore, municipalities purchase child and youth mental health services on behalf of all their inhabitants. Patients who want to be treated by a provider which is not contracted by the municipality in which they live thus need to seek care from another provider or move to another municipality, creating a de facto monopoly for municipalities as purchasers of child and youth mental health services. In transferring services to the YA, municipalities have also been assigned the task to reduce health spending, which provides an incentive for them to exercise their monopsony power. Initial reports indicate that two thirds of all mental health providers expect waiting lists to occur due to the low amount of services contracted by municipalities [24].

4. The quality question

Being prudent purchasers of mental health services implies purchasing care against the lowest possible costs and of the highest possible quality. Defining and measuring quality of care is thus essential. The first set of performance indicators for mental health organizations was introduced in 2006 and it measured three dimensions of quality of care; patient experience, effectiveness of the treatment, and patient safety. Parties agreed to only adapt the indicators in case there was a need to. However, the validity and reliability of the initial set of indicators was questioned as they were perceived to be too aggregated. Therefore, the set of performance indicators was revised several times between 2006 and 2014. Some indicators were dropped or redefined over the years, making it difficult or impossible to compare data across years [20,25].

Initially, mental health organizations were free to choose which instrument they used to measure each of the quality dimensions. In 2010 the Consumer Quality index (CQ-index) became the obligatory instrument to measure patient experiences. Although the index was perceived as a reliable tool for basic, outpatient, mental health services, low response rates led to questions concerning generalizability of the data [25]. Furthermore, it was perceived as a less reliable tool for more complicated mental health patients [25]. In terms of treatment effectiveness, the involved stakeholders agreed that by 2010 Routine Outcome Monitoring (ROM)-measures should be available for 20% of all DTCs billed by integrated mental health providers. However, that goal was not met [25]. As of 2012 providers were obligated to measure treatment effectiveness based on ROM instruments. Although the percentage of DTCs for which ROM measurements were available has increased over the years, the goal of having ROM-measures for 50% of all DTCs by 2014 was not met either [20]. Furthermore, providers use at least six different, not equally sensitive, types of ROM-instruments [26], complicating comparison across providers [20]. Lastly, the set of performance indicators used in mental health has lacked case-mix correction [25]. Although in 2015 initial attempts at case-mix correction were implemented, the performance indicator measures of previous years have been described as incomparable across organizations [20].

While the role of quality in the purchasing of child and youth mental health services by municipalities remains unclear, contracts between mental health providers and health insurers regarding adult mental health care predominantly focus on increasing the transparency of quality. That is, supplying performance measurements and waiting times are examples of criteria insurers use to offer providers higher prices or higher price ceilings. Purchasers seem insensitive to actual quality differences. With the exception of one insurer, which uses its own quality measurements, the Dutch health authority has no knowledge of health insurers selectively contracting providers based on measured quality differences [20]. Providers offering high quality care are thus not 'rewarded' with higher prices for their services, making price the dominant differentiating factor.

5. Conclusion

Mental health care is one of the largest expenditure areas of the basic insurance package in the Netherlands [16]. Since 2008 the sector has undergone several reforms in order to make it more competitive and hence more financially sustainable. However, it remains unclear to what extent the current competitive elements in mental health stimulate value-creating competition [27]. The introduction of pro-competitive reforms has entrusted the transition towards high quality care at affordable costs to a market-led negotiation process between a mixture of decentralized private (i.e. insurance companies and providers) and public (i.e. municipalities) actors. While these actors display rational behavior given their position and role within the system, overall mental health spending has increased rather than decreased [11,16] while quality of care remains ill-defined, incomparable, and in some cases unmeasured [20,25]. Although vigorous attempts are made to adequately define and measure it, quality still plays a limited role in contracting mental health providers and insurers and municipalities predominantly scrutinize providers based on price. Although the Dutch health authority favors high purchasing power (i.e. high power of municipalities and insurers) as long as it results in lower premiums for the patients [19], over-scrutinizing price without being sensitive to quality aspects leaves Dutch mental health stuck between a well-functioning competitive sector and it's former budgeting system.

To abide by increasing cost constraints and the rapidly and constantly changing external environment, mental health providers will have to quickly modify their internal routines, cost structures, strategies, and customer bases. Because outpatient services are increasingly offered in primary care settings for example, integrated mental health providers might lose an important share of their revenues, pressuring them to undergo rapid internal change to maintain profitability in a changing environment. That is, their business model and the way they create value need to be quickly revisited. However, the healthcare sector is

highly professionalized and notoriously slow in adopting technological and organizational innovations [28]. Faced with rapid and daunting price reductions providers may therefore opt for quick-fix solutions, such as selling property or downsizing personnel. While such initiatives could enable them to offer their services at lower costs and secure contracts with insurance companies and municipalities in the short-run, they potentially hamper quality of care and sustainability of the sector in the long-run. The difficulties in defining and measuring the quality of mental health services undermine the assumptions of well-functioning markets. Introducing competitive elements in mental health care could therefore have unintended or adverse effects.

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